

***“It’s a nice place, a nice place to be”: the story of a practice development programme to further develop person-centred cultures in palliative and end-of-life care***

**Abstract**

***Background***

Palliative and end of life care services need to be person-centred. However, it cannot be assumed that such services are ‘naturally’ person-centred as in reality they face the same pressures and challenges as any other service. This is the case in the practice development research reported in this paper. Whilst the service had good patient and family feedback/satisfaction, the context of care provision for staff did not reflect these same levels of satisfaction. This contrast poses challenges for organisations in the context of staff well-being and the sustainability of person-centred care. The work undertaken in this project aimed to address this issue.

***Aim***

To implement a programme of practice development to further the development of a culture of person-centred practice in the Marie Curie Care (MCC) Edinburgh Hospice.

***Methods***

The programme was theoretically informed by The Person Centred Practice Framework of McCormack and McCance (2017) and operationalised through the methodology of Transformational Practice Development. Thirteen multidisciplinary team members formed a project group and participated in 10 x 4 hour workshops of learning and development, spread over a 12-month period. Practice development activities were planned in-between the workshops to be undertaken by the group members. Evaluation data were collected prior to the practice development work commencing, as a continuous process throughout the 12-months and at the end of the project period. Data collected included patient and staff stories, practice observations, creative expressions and routinely collected data. These data were analysed through a participatory approach with the group members and theorised through the lens of human flourishing.

***Findings***

The findings are located within a framework for exploring the conditions for human flourishing. They illustrate the tension between person-centred care and person-centred

cultures. Key findings demonstrate the need for all persons to be 'known' in order for effective person-centred relationships to exist, the significance of shared values, the importance of addressing 'small' practice changes as well as the need to ensure the hearing of different voices. Findings from routine collected data further demonstrate the relationship between the development of a person-centred culture with patient and staff outcomes.

### ***Conclusions and Implications for Practice***

This project is one of the first to explicitly use a framework for human flourishing to analyse the relationship between person-centred culture and care provision. The programme demonstrates the importance of person-centred cultures for sustainable person-centred care. Implications for practice include:

1. Practice settings need to be clear about the difference between patient and person-centredness.
2. The engagement of a multidisciplinary team in interdisciplinary systematic transformational practice development has the potential to transform the culture and context of care and produce sustainable outcomes.
3. Human flourishing is an appropriate focus to adopt in exploring how practice settings embrace the principles of person-centredness for all persons.

### **Keywords**

Person-centredness; person-centred culture; human flourishing; end of life care; hospice; facilitation

## INTRODUCTION

This paper presents a report of the structure, processes and outcomes of an 18-month practice development programme at Marie Curie Hospice, Edinburgh focusing on the development of a person-centred culture in the hospice. The paper describes the background to the programme, the aims and objectives, the theoretical perspectives that shaped the programme framework, evaluation methods and key findings. A shared finding from the programme among participants was the sense that the programme enabled staff to flourish and so the discussion of the findings will be presented through the lens of ‘flourishing’ and its alignment with the development of person-centred cultures

## BACKGROUND

Current evidence suggests person-centred ways of working are crucial in palliative and end of life care (Yalden et al. 2013; McMillan Cancer Support 2013; 2015). Respecting persons’ needs and wishes, shared decision-making, family involvement and sensitive communication are highlighted in the literature (Leadership Alliance for the Caring for People at the End of Life 2014; van der Eerdener et al. (2016). van der Eerdener et al. (2016) reported a qualitative study exploring the experiences of patients’ and their carers’ person-centred end of life care in five European countries. Participants reported experiencing person-centred care when they felt valued as a person-rather than being an illness, were able to discuss prognosis and treatment openly and honestly made possible through formation of trusting, personal relationships. ‘Being there’ and information sharing between professionals which reduced the need for repetition of their story were also identified as hallmarks of person-centred care.

Marie Curie Care (MCC) has an overall strategic direction of the development of person-centred palliative and end of life care, reflecting this evidence. It also reflects the ‘Ambitions for Palliative and End of Life Care: A national framework for local action 2015– 2020’ (National Palliative and End of Life Care Partnership 2015). Embedded within Marie-Curie's strategy and 5-year plan are their espoused values,

*‘Always compassionate, making things happen, leading in our field and people at our heart’.*

The People Strategy (Marie Curie 2015) highlights the need for recruiting and retaining an appropriate skilled and diverse workforce who feel confident and capable to deliver care and experience well-being whilst embracing change and keeping quality improvement central. However, McCormack et al. (2017) posit person-centredness will only happen where there are cultures in place that will enable staff to experience person-centredness for themselves. The organisation therefore decided to use The Marie Curie Edinburgh Hospice (thenceforth referred to as 'The Hospice') as a case study for developing and modelling a person-centred culture, as a means of exploring how the processes could be transferred across the organisation as a whole and identifying outcomes that could be used to demonstrate effective workplace cultures in action.

The programme built on the learning from previous projects that have focused on the development of person-centred services (Boomer and McCormack 2010; Manley et al. 2011; McCance et al. 2013; McCormack et al. 2015) and aimed to further develop the processes used and outcomes achieved. Experience and evidence from practice and research has shown that person-centred care is more likely to be implemented where there is a culture that integrates person centred thinking into everyday work (Yalden 2013). This is particularly important for new or developing organisations. Task orientated ways of working and hierarchical ways of thinking can easily become the norm in organisations that do not make explicit their commitment to a more person-centred approach. The culture of an organisation is often described as "the way things are done around here" (Drennan 1992). This definition is superficial and does not reveal the reasons why things are done in the way they are. Schein (2013) suggests there are three layers to culture. Artefacts are the visible aspect of culture, espoused values are at a deeper level and may emerge through some evaluation methods. Basic assumptions, however are unconscious or taken for granted ways of seeing the world, are the invisible aspect of culture and remain hidden from view. According to Manley et al (2011) workplace cultures are those that impact at the point of care delivery. They suggest effective workplace cultures reflect person-centredness, lifelong learning, effective leadership and teamwork, evidence use and development as well as openness to change. Person-centred practices seek to raise consciousness of espoused values and behaviours. Challenging assumptions and traditionally held beliefs occurs by creating safe environments

where individuals and teams are able to explore meaning of person-centredness and high support and challenge is offered by giving and receiving feedback.

Emancipatory and transformational practice development are identified as methodologies for bringing about culture change that are consistent with the values underpinning person-centredness (McCormack and McCance 2010). The aim of transformational practice development is to increase effectiveness in person-centred practice through enabling healthcare teams to transform the culture and context of care and in this case, to transform the experiences of care by staff and service users/families (McCormack & Titchen 2007; Titchen & McCormack 2008; Titchen et al 2011). In essence, transformational practice development focuses on creating the conditions for all persons to flourish, as a process (ways of working) and as an outcome (the person's experience). This is achieved through a series of phases aimed at helping all staff become empowered to act, utilising staff knowledge and expertise to identify the need to change, encouraging reflection on and in practice and supporting staff to challenge themselves and each other and take ownership for addressing barriers. This is followed by carefully planned action, evaluation and processing of learning to maximise it being translated into further action in practice thus improving quality of care experienced.

Implementation of a programme of practice development ensures that a culture of openness, respect and trust is fostered and embedded in the organisation and that the values and beliefs of patients, relatives, and all grades of staff are recognised and utilised to develop a shared vision of person-centred practice. Experience from previous similar programmes has shown that success is achieved by including all grades of staff in the practice development programme (Boomer and McCormack 2010; Manley et al. 2011; McCance et al. 2013; Yalden 2013; McCormack et al. 2015) and that there is a direct link between the participation of leaders in the programme and outcomes achieved (McCormack et al 2009; Mekki et al 2017).

## **PROGRAMME AIM AND OBJECTIVES**

To implement a programme of practice development to further the development of a culture of person-centred practice in the MCC Edinburgh Hospice.

## **OBJECTIVES**

1. Enable participants/key facilitators and managers to recognise the attributes of person-centred cultures in hospice care and key practice development and management interventions needed to achieve the culture (thus embedding person-centred care within the organisation).
2. Facilitate learning and development about transformational practice development to support person centred practice in the hospice setting.
3. Promote quality of care and wellbeing for all patients in the care facility.
4. Utilise a participant generated data-set to inform the development and outcomes of person-centred practice.
5. Utilise active learning methods to ensure participants have ownership of the programme and outcomes arising.
6. Develop skilled facilitators who will champion and lead a person-centred approach to practice ensuring sustainability of the practice development programme in the organization.
7. Promote and foster a culture that empowers practitioners and values their endeavours in the delivery of person-centred practice.

## **METHODOLOGY**

The programme was theoretically informed by The Person Centred Practice Framework of McCormack and McCance (2017): This framework provides a way of thinking about a care environment as a person-centred culture and a place that embraces meaningful engagement with people as colleagues and as residents/families. To operationalise this theoretical perspective, the methodology of Transformational Practice Development was employed. This approach to practice development holds central a focus on developing cultures that enable all persons to flourish. This is achieved through critical and creative engagement in facilitated learning. The focus of the learning is the individual practitioner's/individual teams' work. Through creative and critical reflective activities, learners are enabled to bring about change in themselves and the cultures and contexts in which they practice. The learning is set within a strategic context to ensure it is embedded in organisational cultures. The methodology of transformational practice development was operationalised through active learning (Dewing

2006). This is a form of action orientated learning concerned with work and work practices whereby the style of learning and consequent activities is underpinned by principles of active engagement in observation of care and practice by self and others, critical reflection with self, critical dialogue with others and doing or action with others in the workplace. Participants are guided to increase the range of active learning methods they use in their day to day work, who in turn learn to use active learning methods in their workplaces with team colleagues.

### ***The Setting***

The Edinburgh Hospice is one of nine Marie Curie hospices across the UK. All of the services offered by the hospice work together to meet the palliative care needs of people with progressive, life-limiting illness. The aim of the service is to provide specialist, research-based palliative care which enhances quality of life for people affected by cancer and other illnesses. The hospice inpatient unit employs more than a hundred staff to provide care and support for up to 20 adults over the age of 16. In addition, day and community services operate from the hospice in Edinburgh and from the Macmillan Centre in Livingston, West Lothian. A team of trained volunteer staff also support the hospice in various activities such as working on the reception, offering drinks and snacks, and gardening.

### ***The Participants***

The programme commenced with a group of 13 people from mixed disciplines: The Hospice manager, Practice Development Facilitator, two Lead Nurses, one Charge Nurse, one Clinical Nurse Specialist, two Registered Nurses, two Health Care Assistants, one Secretary, one Physiotherapist and one Medical Consultant. The group membership changed over time for a variety of reasons including sick leave, retirement and leaving the organisation.

### ***Programme Structure***

The programme was structured over 12 months and centred around 10 'programme days' of learning and development (Table 1).. Each of these programme days incorporated 3 hours of facilitated active learning with the 'core group' (the co-authors of this paper) on the identified themes.. Whilst the programme appears linear in design, in reality each session incorporated elements of previous learning and responded to the learning and development needs of the

207 participants.. The focus of each programme day and the activities engaged in were informed  
 208 by the work of Dewing, McCormack and Titchen (2014):  
 209

<b>Day</b>	<b><i>Programme Day theme</i></b>	<b><i>Programme Day Focus and active learning/practice development activities</i></b>
1	Knowing and demonstrating values and beliefs about person-centred practice	<ul style="list-style-type: none"> <li>• Reflection on own values and beliefs.</li> <li>• Identifying the values and beliefs of all who work in and receive services from the hospice.</li> <li>• Putting values and beliefs into practice.</li> </ul>
2	Developing a shared vision for person-centred practice	<ul style="list-style-type: none"> <li>• Setting up a practice development coordination group.</li> <li>• Creating and sharing personal and organisational visions.</li> <li>• Development of an organisational vision statement.</li> </ul>
3	Developing teams and building an effective culture of person-centredness	<ul style="list-style-type: none"> <li>• Observations of care and patient/staff stories.</li> <li>• Identifying personal and group attributes.</li> <li>• Recognising the context in which care is delivered.</li> </ul>
4	Introduction to evaluation	<ul style="list-style-type: none"> <li>• Developing evaluation questions.</li> <li>• Methods for gathering evidence in the care setting.</li> <li>• Observations of care (WCCAT).</li> <li>• Patient and staff stories.</li> <li>• Giving and receiving feedback.</li> </ul>
5	Working with stakeholders in co-designing a person-centred service	<ul style="list-style-type: none"> <li>• Maintaining identity in the care setting.</li> <li>• Compassion, dignity and choice.</li> <li>• Drawing on multiple voices.</li> <li>• Reflective learning.</li> <li>• Evaluation.</li> </ul>
6	Action Planning	<ul style="list-style-type: none"> <li>• Linking the person-centred practice framework, practice development model and action plans.</li> </ul>



		<ul style="list-style-type: none"> <li>Identifying indicators to prioritise action planning.</li> </ul>
7	Mini-projects	<ul style="list-style-type: none"> <li>Translating the action plans into action through ‘mini-projects’.</li> </ul>
8	Learning in the Workplace.	<ul style="list-style-type: none"> <li>Creating a person-centred learning environment.</li> <li>Giving and receiving feedback.</li> <li>Active learning processes.</li> <li>Reflective practice – key processes.</li> </ul>
9	Sharing and Celebrating	<ul style="list-style-type: none"> <li>Acknowledging achievement.</li> <li>Acknowledging and celebrating achievements in the working day.</li> <li>Sharing and celebrating with local communities.</li> </ul>
10	Follow up evaluation 3 months post day 9	<ul style="list-style-type: none"> <li>Reengagement with practice development group.</li> <li>Workplace-culture Critical Analysis Tool (WCCAT).</li> </ul>

**Table 1: programme days of learning and development**

## **Evaluation**

On-going evaluation was built into the programme and this evaluation informed both the structure and layout of the programme days and the ongoing active learning activities. There was also the intention to undertake formal evaluation with data collected at 2 points throughout the programme but how this would be collected would be agreed with the participants. Initial baseline data were collected at the beginning of the programme, comparative data were collected after day 10 and analysed in a follow up day between the programme participants and the lead facilitators. The intention was that data collected at time 2 would focus on assessing the embeddedness of person-centred practices within the organisation. However, following the baseline data collection, the participants expressed concern that the data collection processes wouldn’t tell a story of connectedness, embeddedness and transformation that was experienced. They suggested that over time there would be many examples of practice and culture changes that would show how the

baseline data were being used and built on in practice. We needed to capture 'practice illustrations' to show how changes in practice enabled team members to flourish, and as a consequence how flourishing people and places enabled effective service-user engagement. The team agreed to include graffiti boards to capture examples of person-centred practices observed by anyone who wished to contribute.

*Data Collection:* The processes and outcomes were evaluated within a collaborative framework drawing upon reflective dialogue data between lead facilitators and project participants, individual interviews with key stakeholders and observations of practice using the Workplace-culture Critical Analysis Tool (WCCAT) (McCormack et al 2009). The aim was to gain insight into the deeper layers of culture as proffered by Schein (2004; Manley et al. 2011) and person-centred practices (Titchen 2001; McCormack and McCance 2017). Data gathered using these multiple methods were analysed to identify changes in the practice culture at the beginning and the end of the project. Data were collected during October 2016 by a research assistant, neutral to the project. Four observations of practice were undertaken in the Day unit; one in the hospice reception area, one in the staff canteen, 21 in ward 1 and 24 in Ward 2. Each period of observation was 30 minutes duration. Twenty-eight individual interviews were conducted, each between 4 – 24 mins duration. Interview data were collected from 15 members of staff including, 11 nursing staff, one medical doctor, two catering staff and one member of the reception team, 7 patients, two family carers and four volunteers.

*Data Analysis:* Baseline data were collected to evaluate existing practice against the shared vision developed. Data collected from 'sit down' and 'walk around' observations, patient & staff stories which were recorded and transcribed and use of existing data e.g. compliments, complaints, surveys (patient and staff). Patient and staff stories were analysed by the QMU Research Assistant. WCCAT data were analysed as a participatory process among the programme participants using Creative Hermeneutic Data Analysis (Simons and McCormack 2007; Boomer and McCormack 2010). Findings were compared with the interview and questionnaire data to triangulate and determine appropriate action to be taken. All data were then mapped onto a matrix we developed derived from The Person-centred Practice

Framework (McCormack & McCance 2017), so that two matrixes were used to compare the data at time 1 and time 2 (an example of the mapping matrix is presented in Appendix 1). In addition, analysis of the development data was undertaken with the participants and the external facilitators. The participants identified the specific activities they had engaged in, reviewed/considered the data they had collected to inform these developments and together with the external facilitators reflected on how this impacted on the culture. Practice examples from the graffiti boards were also reflected on. A timeline of changes was created to help the participants plot the journey over time and what had been achieved. At the end of the project, the team conducted a collaborative reflective workshop where they identified outcomes of the culture transformation, identifying how this reflected their shared vision and their shared understanding of the reasons for this transformation. A framework of 'human flourishing' was used to shape this reflective workshop.

The concept of 'human flourishing' exists as an ancient concept in highlighting the importance of persons being able to live a fulfilled life. In an analysis of the concept of human flourishing, McCormack and Titchen (2014) identified 8 conditions for people to be able to flourish. These conditions were used to explore the relationship between the development activities engaged in, the practice changes identified as examples of team members, service users and families flourishing as a result of the development activities and data collected through formal data collection activities.

### ***Ethical Approval***

Ethical approval to conduct the study was secured from QMU Ethics Committee and the Marie Curie Research Group.

## **FINDINGS – THE UNFOLDING OF A STORY OF FLOURISHING**

*Human flourishing occurs when we bound and frame naturally co-existing energies, when we embrace the known and yet to be known, when we embody contrasts and when we achieve stillness and harmony. When we flourish we give and receive loving kindness. (McCormack & Titchen, 2014)*

The term 'human flourishing' can be traced back to Aristotle who suggested that 'human

*flourishing occurs when a person is concurrently doing what he [sic] ought to do and doing what he wants to do'. Aristotle's moral perspective of human flourishing is at the heart of what it means to be a healthcare practitioner, with a moral requirement to do and want to do the right thing for others. McCormack and Titchen (2014) argue that to achieve this outcome requires an understanding of what is required of us as practitioners (the evidence that informs our practice) whilst at the same time being in a position to want to do what is the right thing and to enjoy doing it. McCormack and Titchen built on this Aristotlean position and through a process of critically creative inquiry, identified 8 conditions for persons to flourish:*

1. Bounding and Framing
2. Co-existence
3. Embracing the known and yet to be known
4. Being still
5. Living with conflicting energies
6. Embodying contrasts
7. Harmony
8. Loving kindness

We use these eight conditions for human flourishing to re-present the processes and outcomes arising from the transformational practice development programme reported in this paper.

### **Bounding and framing**

McCormack and Titchen (2014) suggest developing a 'frame' of reference for both how we see the landscape (the culture) of the setting and the direction of travel we need to adopt to enable the subtleties of the landscape to be observed, engaged with and lived. A developed understanding of the need to pay attention to the existing culture of practice to enable person-centred services to evolve was required. Thus, the journey began by the group getting to know each other, not by their job role, but as people. This is fundamental to person-centred practices and is a way of encouraging people to authentically engage with each other (ref) and to achieve connectivity which Gaffney (2011) suggests is vital to human flourishing. Each member of the group was invited to create their own self-portrait, using creative materials.

318 This proved to be enlightening and fun. Whilst at the time, the group felt too much time had  
319 been devoted to this activity, they came to know this was part of establishing the path on  
320 which they would journey and throughout the programme, referred back to elements of  
321 'knowing' each other they had developed through this activity. The portraits exercise also  
322 enabled the basis of a discussion about shared values to be developed.

323

324 Person-centred cultures are rooted in explicit values which are reflected in a shared vision.  
325 This vision would become the evaluative statement, central to the work of the project.  
326 Individuals in the group were encouraged to undertake a values clarification exercise. They  
327 were asked to reflect on five statements:

328 I believe the purpose of a person-centred culture is.....

329 I believe a person-centred culture can be achieved by.....

330 I believe factors that enable a person-centred culture are.....

331 I believe factors that inhibit a person-centred culture are.....

332 I believe other factors about a person-centred culture are.....

333 The dialogue that followed this activity enabled the group to establish ways of working  
334 together in a person-centred manner. They also developed three different vision statements  
335 in small groups that reflected their espoused values. The group recognised they would have  
336 to find ways of engaging with all stakeholders, including patients, carers, volunteers and staff  
337 to ensure everyone's voice was heard and for the values to be truly shared. They were  
338 encouraged to repeat the process within their own areas of practice using creative methods  
339 as they saw fit. The group used graffiti boards, existing formal meetings, conversation and  
340 imagery and the same written values clarification exercise. The data collected were analysed  
341 using critical creative hermeneutic analysis by the group members and the facilitators. Key  
342 values were extracted and compared to the initial vision statements. The group then worked  
343 together to develop a shared vision statement that would serve as the anchor of the project:

344 *'Our vision for a person-centred culture is one that enables individuality, promotes*  
345 *autonomy and encourages aspirations in a secure and supportive environment'.*

346

347 **Co-existence**

The core group used the vision statement as a marker of the existing culture. Data were collected and analysed to understand what needed to be done in order to realise the vision. To achieve human flourishing, being attuned to the connections that exist in the care setting enabled the group to recognise when disconnections were happening and for us to be able to rise to the challenges associated with such disconnections. The challenge is to appreciate how individuals are interconnected in manifesting the elements of flourishing and beauty that exist within each team member. The group pondered the question posed by one of the facilitators, *'how can we find out what the current culture is like?'* Through dialogue, the data collection methods were agreed upon. Data were collected by group members, as well as the research assistant and included, sit down observations of practice; walk around observations of practice; and, patient & staff stories (recorded and transcribed).

Once the data were collected, it was mapped onto a data mapping matrix (Appendix 1) derived from the Person-centred Practice Framework of McCormack and McCance (2017). Through a process of Critical Creative Hermeneutic Data Analysis (Boomer 2010; Bright 2015) the core group worked with the matrix and identified five overarching themes from the data:

1. Knowing the person
2. Promoting individuality
3. Balancing routines with informed choice
4. Team effectiveness
5. The physical environment

### **1. *Knowing the person***

The theme of 'knowing the person' reflected the extent to which staff in the hospice made efforts to know patients and families. Observations reported:

*"A very good rapport exists between the patients and the staff. No one is talked down to.*

*They are all treated as adults" and:*

*"Assistance is offered to those who want it or require it. There is no offering assistance if the person is able to do the task for themselves".*

Not only do these actions demonstrate the determination of staff to maintain patient independence, but it also highlights the respect the staff have for maintaining patient dignity.

Members of staff offered a 'personal touch' to the care they provided:

379 *"Every day I say to them, what's on the menu... I said no, not soup. She says wait a minute*  
380 *and I'll ask the Chef what he's got; and she came back as she says omelette. I said stop*  
381 *before you get anywhere else... an omelette... it was one of the best foods, meals I've ever*  
382 *had. Brought out by the cook you see, now he obviously had the time to do it; but he brought*  
383 *it out and said, 'how did that do you?'"*

384 One patient reported:

385 *"They've got your name. I'm not William, I'm Bill". A relative stated that, "The staff know*  
386 *about me and my circumstances which is fantastic. It seems to be about me and not my*  
387 *mum"*.

388 In an interview, a patient commented:

389 *"one thing I have noticed, the nurses often don't get 5 minutes peace, but when they do they*  
390 *don't go away and have a cup of tea, they come and chat with the patients just to see how*  
391 *their day is going and to give them a bit of company, the ones that don't get visitors"*.

## 393 **2. Promoting Individuality**

394 Enabling patients to express their individuality was generally a positive aspect of services at  
395 the hospice. In one interview, a member of staff stated:

397 *"I think it's sometimes difficult for patients to realise that they're actually allowed to do that*  
398 *here (express individuality). Especially (comparing to acute care) for prolonged stays in more*  
399 *acute settings where you do have to fall into a bit of a routine. ...I think that a lot of*  
400 *patients... not exclusively but especially older patients have this thing that they can't cause*  
401 *too much trouble, and sometimes you have to encourage people and say... well actually it's*  
402 *for our benefit as well if you're as happy as you can be while you're here"*.

403 In another example, a member of staff suggested:

404 *"but there are routines and everything, there's probably like the meal times and things is a*  
405 *bit of a routine that they are kind of expected to eat at that time. ...If they wanted to order*  
406 *something for a different time they could but I think that probably the way it is offered isn't"*.

407 The 'problem' of some patients not understanding that they are permitted to ask for things,  
408 and that it is a part of the service that the hospice provides, is a challenge. Perhaps there is a

409 routine being projected to patients which causes them to assume that this is the expected  
410 norm.

411 Most members of staff agreed that they were providing individualised care but some believed  
412 that they could be doing more. One such comment stated:

413 *"I think there are certain aspects that I would like to see changed to see people express their*  
414 *individuality more.... So things like people using their own bed linen..."*.

415 However, some members of staff were cautious about increasing the individuality within the  
416 care setting and establishing where the line should be drawn. One example given by a  
417 member of staff was how to ensure a safe "infection control" environment and that the  
418 environment remains "functional" and "safe", whilst offering a person-centred approach to  
419 their care.

420

421 In one statement a member of staff reported:

422 *"I think the ward team is respectful of people's individuality and are open to different*  
423 *cultures and beliefs, lifestyles. And we are flexible to a large degree about enabling people to*  
424 *continue their own lifestyles, even if that includes extremes such as drug taking... but then*  
425 *there has to be boundaries and sometimes those boundaries are quite broad"*. Furthermore,  
426 *"We see people getting frailer and more unwell. I think there is a definite area of risk versus*  
427 *reward... they are a bit shaky on their feet and you feel they should have a stick or a*  
428 *wheelchair. You're looking at them and thinking it's their life, their mobility. We shouldn't*  
429 *just tell them that it's up to other people to decide, physio's and things. But we support them*  
430 *as best we can"*.

431 Staff were observed to endeavour to respect the beliefs and wishes of each individual patient:

432 *"We try to give the patient what they want... their faith, their dietary... they will be*  
433 *accommodated... their dog in, family to be involved in their care... we try to accommodate but*  
434 *we also try to encourage"*. *"There was a guy on the floor..., he liked his halal diet and he only*  
435 *liked it at half seven at night"*.

436

437 However some interview data suggested that there can often be a disparity amongst family  
438 members regarding the care of their loved one. One such comment stated:



439 *"the needs of families get lost in the mix of things. We do our best, sometimes they have*  
440 *different ideas of what they want. Some patients want to go home and the family can't*  
441 *cope. Sometimes we've got to manage that and it's a bit off sometimes".*

442  
443 Overall, the staff at MCC attempted to promote autonomy and individuality with patients,  
444 whenever it was safe and feasible to do so:

445 *"So I said to them (the patient), you don't give yourself enough credit when you're able to do*  
446 *things... and to encourage them instead of underestimating what they are able to do. And*  
447 *they come back and say, yes you're right. (Promoting autonomy)".*

### 448 449 **3. Balancing routines with informed choice**

450 One key message that came from the feedback provided was that the staff took steps to  
451 enable them to spend more time with the patients, and ensured that the patients' dignity was  
452 preserved. One member of staff said,

453 *"He (patient) was quite confused and agitated this morning, worrying about clothes and*  
454 *things. And I had that time to sit down and explain ...you don't need to worry your wife. Here*  
455 *it is great, you can take that time to find out, especially if something is worrying someone".*

456 One relative provides their personal experience of this by telling us that

457 *"The Marie Curie staff treat Mum with respect, I can't complain about anybody. The care she*  
458 *has had is excellent. Pretty fantastic really".*

459 It was subsequently observed that many members of staff always took precautions to ensure  
460 that the patient's dignity was maintained when talking to relatives, or other members of staff  
461 about the patient. This is evident in the observations:

462 *"A doctor is talking to relatives in the corridor. She is discreet and their voices do not travel",*  
463 *"A patient is receiving one to one care; I could not tell what kind of care it was. I could not*  
464 *hear the voices of the staff inside. Well done."* and *"The voices of the receptionists don't*  
465 *travel maintaining good levels of confidentiality".*

466  
467 It was also evident on the wards that the staff always treated each patient with a high level  
468 of respect. In one observation it was reported that,

469           *"Potential interventions and medication changes discussed with patient"*, whilst  
470 subsequently in another observation *"Nurses are walking about doing their drug rounds, the*  
471 *nurse is quiet and respectful of the patient's privacy when giving out the meds"*.  
472

473 One key theme that was very encouraging was the comments that elaborated on the staffs'  
474 attitude and approach to care. One member of staff told us

475           *"I've often seen the consultant on the ward round ask patients about drugs and other*  
476 *aspects of care...they'll be asked their permission... they don't just take the <care record>*  
477 *and say we're going to give them this today...permission is always sought from the families*  
478 *as well"*.  
479

480 Various observers left similar comments regarding the staff's attitudes and approaches to  
481 their patients. One observer reported that, *"Staff are friendly and courteous to the relatives*  
482 *if they require or ask anything"*, and another said *"The staff, even although they are busy*  
483 *always make time to stop and chat or laugh with the patients"*.  
484

485 When someone had died, the ward's tone shifted to one of respect. *"The relative's room is*  
486 *readied for use by a pair of staff. They have just lost someone. Every member of staff treats*  
487 *them with respect and remorseful"*. Any discussion between the staff and the relatives is kept  
488 very private and respectful. *"Body language and facial expressions...very positive and*  
489 *encouraging"* and any conversation *"with relatives happens behind closed door. It is very*  
490 *private and no voices can be heard through the door"*. *"Gentle chatting between nurse and*  
491 *family members"*. The level of respect on this ward was reported as high, and everyone  
492 conveyed their sympathies to the relatives. There was an almost 'unspoken rule' and  
493 procedure which commenced as soon as a patient **died**. Each member of staff knew exactly  
494 what their role was in this procedure. This ran smoothly and did not add to the grief of the  
495 relatives, felt natural, and therefore went largely un-noticed by the relatives.  
496

497 There were many responses identified that demonstrated that the staff in the hospice include  
498 their patients' in any decisions needing made regarding their care:

499 *"When do they want to wash, if they want papers in the morning, like a routine for us but*  
500 *also for the patients as well, if they want to stay in bed for breakfast? Do they want a wash*  
501 *today? You've just got to ask them what they like... If they want it in the afternoon that's*  
502 *fine... if they want it in the evening, that's fine".*

503  
504 Another member of staff stated, *"I know you are here to promote person centred care and I*  
505 *do think that for the patients. I always think the patient is the person that makes the*  
506 *decisions... they're in charge of themselves".* From these two statements, it is evident that the  
507 patient's choices and independence is encouraged by the staff. Furthermore, the members of  
508 staff encourage the patient's individuality and respect their patient's beliefs. In an interview  
509 with a patient, the patient stated, *"Pastor came to visit when I first came as I am a Roman*  
510 *Catholic. I asked if I could have communion. He was very helpful to me. He came back on the*  
511 *Monday to see if all was I had wanted".*

#### 513 **4. Team Effectiveness**

514 There were many positive examples of staff cooperation and multidisciplinary working  
515 including:

516 *"The other ward is short of staff and requests staff to help with jobs that require two nurses.*  
517 *The staff on this ward quickly find someone who is not too busy to send down".*

518  
519 However, in other comments staff stated:

520 *"Sometimes HCAs don't understand why S/Ns can't do washes" etc or "Members of the team*  
521 *not valuing other's roles, Domestic trying to do their job but no discussion with them during*  
522 *this with nursing team on the floor".*

523  
524 This highlights that there is a lack of understanding of the roles of other health professions on  
525 the wards. The perceived 'value' of the contributions offered by different members of staff  
526 was raised. One member of staff stated:

527 *"If you treat your staff well and are flexible with them, then they will give back to you in*  
528 *return. If staff are constantly denied the opportunity of flexibility then they become resentful*

529 *and eventually leave to work elsewhere. There needs to be a culture of trust and respect so*  
530 *that you know if you are flexible then people won't take advantage of it".*  
531

532 There some observations made of members of staff 'moaning' about new staff that had been  
533 appointed, and attempting to drag other members of staff into the conversation. Some staff  
534 expressed that they believed that the roles of the various multi-disciplinary teams should be  
535 taught to the different staff on each ward. Another believed that an understanding of how  
536 the hospice and day services interlink, and the services they provide should subsequently be  
537 taught. Many members of staff reported that they were, *"Generally very happy. I really enjoy*  
538 *my job and I love my team"*.

539  
540 However, in the narrative interviews, different views were expressed about staff  
541 communication in the hospice:

542 *"Some HCAs are excellent at communicating concerns with patients"*. Alternately, there  
543 were negative comments, including, *"Some HCAs are poorer at communicating"* and  
544 another reported, *"I feel that HCAs are undermined"*.

545

546 One member of staff reported that:

547 *"Communication is something that is continually discussed as an issue. Sometimes it's not*  
548 *clear when to communicate with the different departments and often small communication*  
549 *errors occur, for example keeping reception informed with incoming patients etc"*.

550

551 Another member of staff stated that:

552 *"communication could be better about things happening for staff, to avoid problems. In*  
553 *certain areas some people have a sense of entitlement and don't appear willing to*  
554 *contribute or support other people"*.

555

556 Some observations highlighted the need for better communication over the course of the day  
557 and at hand over. There was one observation made where the observer overheard a  
558 conversation that was going on in the corridor. During a narrative interview, one relative  
559 complained that

560       *“My Mum has dementia and some of the agency staff have treated her like a child\_ wash*  
561                               *your hands now, smell them. Oh they smell lovely”.*

562

563       In a staff interview a member of staff felt that they were being undermined by the changes  
564       that were being made to the hospice, and that the management were not listening to their  
565       concerns. The staff held predominantly negative views of the ward staffing levels. A number  
566       of staff believed that there were often not enough staff on the wards, and as a result *“some*  
567       *patients have to wait for things”.*

568

569       Overall, most members of staff made positive comments about working at MCC:

570       *“I enjoy working here as it is a very worthwhile job and I am made to feel my contribution*  
571                               *counts in what is quite a unique environment”.*

572       Some staff members were leaving the hospice, which was attributed to problems with team  
573       effectiveness. Some staff commented on the ‘emotional labour’ of the job and the need for  
574       greater staff support:

575       *“Worst thing: Stress of working with a caseload. Emotional aspects of the job-sadness/loss”,*

576

## 577       **5. The Physical Environment**

578       Many people commented on the visual aesthetics of the wards. Such aesthetics included the  
579       size of the rooms, the patient’s view of the gardens, the balcony and the bright colours that  
580       coat the rooms’ walls. One person stated that the, *“Front door area is fresh, clean and bright”.*

581       There were some comments about how to improve the overall visual impact of the hospice.  
582       A couple of these comments reported that the lighting in some rooms appeared very dim,  
583       that there were no pictures or decorations on some of the wards, some rooms had no visual  
584       outlook and that there were dead/dying flowers left in a room.

585

586       Comments and observations were made regarding the sounds that were heard whilst on the  
587       wards. Such comments reported that the rooms were quiet, that the patients were heard  
588       chatting to one another in the side rooms, that the staff made an attempt not to speak too  
589       loudly, and that the phones on the ward did not ring too loudly. It was observed however that  
590       there were a lot of noises coming from a machine just off the wards. The patient call-bells at

times were too loud and, “pierces the silence”. Furthermore, a member of staff reported that the wards were at times noisy and that the staff voices travelled easily. One observer reported that they had heard “laughter” and “humour” whilst on the ward.

There were many comments regarding the different odours present on the wards, including at times, the “stale” smell of “faeces” and “urine”. However, others commented on the smells of wood, lemons, sawdust, warm scones or the general aroma of dinner.

Overall, members of staff and the observers found the wards to be “calm” and “peaceful” environments.

### **Summary**

The different data collected largely demonstrated a positive experience for patients and families. The intent to provide individualised and person-centred care was obvious in the data and the efforts that staff went to in doing so, recognised by patients, families and co-workers. However, the theme of ‘team effectiveness’ revealed issues pertaining to team working, team effectiveness, communication and consistency of approach, as well as some issues concerning the general hospice environment. This suggests a focus on person-centred care at the expense of a person-centred culture.

Each of these issues became developmental themes for the core group to work on, in collaboration with other members of the hospice team. At this stage in the programme, the core group also discussed and considered the value of a time 1 and time 2 evaluation framework and instead agreed to use the themes as developmental themes, each one with its own ongoing evaluation and augmented by routinely collected data.

### **Embracing the known and yet to be known<sup>7</sup>**

The team were invited to engage with the data in order to raise consciousness of person-centred practices within the hospice. Interacting with the data was an important part of the process as, to flourish, they need to understand elements of their own personhood, at that time hidden from themselves. McCormack and Titchen (2014) suggest, through a meaningful

engagement with 'other' the hidden gems of our personhood can be revealed and made known to us. Following data collection and analysis of the initial data, the group felt they needed to pay attention to ongoing engagement of patients, staff and volunteers. They raised the issue of not knowing, what Gaffney (2014) refers to as valued competencies. They did not know about each other's talents. They used the forthcoming summer fete to find out about each other, their strengths and willingness to contribute. The group recognised that it is these hidden aspects of persons that need to be surfaced to create a culture that enables all persons to flourish. This event was also used as an opportunity to model person-centredness by enabling all persons associated with the hospice to express those aspects of 'self' that shaped them as persons – their beliefs, values, needs, wants, desires, hopes and dreams. These were reflected in the consideration of the areas for development and how the different talents of staff could be maximised and used as assets to the ongoing development of the person-centred culture of the hospice. 'Mini-projects' were then established, each led by a member of the core group and working in collaboration with members of staff from across the hospice services. Some examples of these are found in Table 2



A further example of overt commitment to new ways of engaging was the public display of the previously developed shared vision. In order to promote the vision and celebrate it as the first collaborative activity of the team, a wordle (ref) of the analysed key words was developed to go alongside the vision statement at the hospice reception area.

	645
• Celebrating the Vision Statement:	646
○ Wordle and display in hospice reception	647
• Admin team development:	648
○ 'Can do approach'	649
○ Improvement in atmosphere and welcome at reception	649
○ Making things possible – shared commitment to the culture of the hospice	649
○ Initiative	650
• Induction	651
○ Multi-disciplinary inductions implemented using PCC tools and approach	651
• Creating Spaces for Reflection	652
○ Schwarz Rounds	652
○ Communicative spaces for open dialogue	653
• People of Marie Curie	654
○ Personal portraits and photos of MC staff and volunteers	654
○ Post on face book and highlighted in hospice newsletter	655
• Hospice Presentations	656
○ 2-hour presentations x 6 annually for internal MC staff and volunteers and external visitors covering all MC services and activities	656
○ Include 'virtual' tour	657
○ Ongoing updates	658
• Staff Support and Development	659
○ Person-centred workshops	659
○ Role clarifying workshops between RNs and HCAs	660
○ Regular team meetings	661
• Reviewing of Existing Data	661
○ Staff Retention	662

**Table**

**2:**

## **Mioni Projects**

### **Living with conflicting energies**

The project offered a unique opportunity for skilled facilitation of 'moments of crisis', described by Fay (1987) as pre-cursors for change in being and doing. Crises aren't major events in a person's life, but instead are 'jolts' that may alter a particular perspective or cause us to pause for reflection and reconsideration of the direction we are taking. From the start of the programme, the core group found it difficult to accept that taking time out of clinical practice to focus on self, then focus on culture change was a worthwhile use of their time. Despite the deepening commitment to the programme, during sessions, there continued to be a pull on participants' time and invariably, there were interruptions and different members were pulled to the clinical area. Although there was enthusiasm to engage and participate in the project and an acknowledgement that time was needed to build robust relationships, they



found it challenging to grasp the importance of learning different ways of being in order to ensure sustainability. Instead the group wanted a graphic representation of the programme, with a clear plan that could be followed. As the programme would draw on principles of PD, rather than a narrow focus of quality improvement or change management, it was important to spend time ensuring collaborative, inclusive, participative means were adopted; building in evaluation and making time for learning in and on the process (Dewing 2008). By adopting this approach, there would be agreement of a shared purpose and vision, development in self-awareness, facilitation, and leadership. This would enable multiple actions to address changes in culture and context required.

Working together to agree shared values and developing a vision for the intended future, enabled the core group to quickly come to understand creative ways of involving patients, families, other staff and volunteers to agree a shared vision. By doing this, from the beginning the programme became a collective endeavour with all stakeholders and a platform for shared decision-making. By day 3, members of the group reported feeling '*things were beginning to happen*' a person-centred learning environment was emerging and, rather than waiting for concrete plans, they had begun examining their practice and seeking local solutions. Whilst evaluating the session by writing a haiku. Participants wrote:

*Much less confused now  
Positive about the future  
Have the team working*

Whilst another member wrote

*Lots of work to do  
Championing. Excited.  
Yes I can do it!*

*The following Haiku was written as part of a Person Centred Workshop for Registered Nurses focusing on workplace:*

*Here we are again  
Talking of workplace culture  
Does anything change?  
Embracing the good  
We must take the blinkers off*

707 *Rejecting the bad*  
708 *Is it that simple?*  
709 *Do all eyes see the same truth*  
710 *Listen, learn and share*

711 Participating in an assessment of the workplace culture and context (Manley et al 2011), there  
712 was recognition of using the shared vision as an evaluative statement that they could work  
713 together to find out what the existing culture and context of care was like and take ownership  
714 of developing person-centred practice. The group also recognised by analysing the data  
715 themselves, themes relating to person-centred care emerged, but team relations were less  
716 visible. The facilitators helped the group to consider how they would collect further data by  
717 modelling person-centred practice and a holistic style of facilitation (Rycroft-Malone 2016).  
718 Conflicting energies emerged in a perceived dissonance with the organisational values and  
719 some worry about the inaccessibility of the language around person-centredness. Rather than  
720 seeking to explain, the facilitators opened dialogue where group members were encouraged  
721 to voice their concern and try, through dialogue to question their thinking. They decided that  
722 it was important not to lose any of the voices that had contributed to the shared vision,  
723 otherwise this would impact on shared ownership. They also decided to update other  
724 stakeholders by identifying how their contributions were visible in the early work. The core  
725 group spent some time thinking of different ways of explaining the vision of person-centred  
726 practice and being part of the programme. Questions were also identified e.g. '*can you please*  
727 *tell me what it is like to work here*', which would give some insight into understanding team  
728 relationships, identified as missing in the data.

729 Consciousness-raising is a key element in transformation. Fay (1987) suggests this is a pre-  
730 cursor to enablement and emancipation. Facilitation of active learning, giving and receiving  
731 feedback and critical reflection were all strategies designed by the facilitators. By creating and  
732 holding a psychologically safe space, the group could experience and harness conflicting  
733 energies to transform themselves and the culture and context of practice.

#### 734 **Being still**

735 Making dedicated time for the programme has been challenging because of the busy  
736 environment within the hospice. Despite commitment of the team, attendance at the PD  
737 meetings was variable. Throughout the programme, the group met at additional times to take

the work forward. Creating spaces for quiet reflection and stillness is a real challenge in busy healthcare environments and there is a need for us to pay more attention to the workings of healthcare environments and how they function. However, we need to focus on the movement contained in the whole rather than the busyness of isolated parts. Creating spaces for quiet reflection, critical engagement and meaningful connection with others are essential elements of an environment that enables all persons to flourish. One example of this is the work the team did on developing Schwarz Rounds.

Schwartz Rounds were introduced to the hospice almost in parallel with the programme. The aim is provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare (Point of Care Foundation). A steering group met up regularly to plan and review every round, taking into account the mood of the hospice, time of year and current issues that would be appropriate to explore in a Schwartz Round. Rounds are generally well attended by staff from clinical and non-clinical areas (20-30 people usually, although 90 when person-centredness was the topic) As with the programme, releasing nursing staff from the ward however has remained an on-going challenge and is currently being evaluated. Feedback was sought from practitioners:

*'Thought provoking' 'Touching, relevant, poignant' 'Thoroughly enjoyed taking part'*  
*'Fab discussion – lots to take away and think about' 'Good to share and learn together'*  
*'Very good, made you stop and think about things, which I think is useful during a busy day'*  
*'Really gave insight in to the value of the team' 'Nice to hear the human side of people'*  
*'Good to hear different perspectives' 'Helps me better understand my work environment'*  
*'Inspiring and bonding' 'I think we are getting better at sharing our thoughts and our fears'*  
*'Very much enjoyed the stories from staff working in different areas / departments of the hospice. Gave a most enjoyable and welcome insight into their roles and the impact this has on people's lives, working in our unique setting of the hospice. Sharing is supportive and very worthwhile. Look forward to the next Schwartz round.'*

An example of how learning is now facilitated in The Hospice, demonstrates a shift towards a person-centred culture - introducing moments of stillness for Healthcare Assistants (HCAs) to

have the opportunity to reflect. The aim being to uncover patterns of practice, both positive, person-centred, as well as ritualistic, task-focussed practices. During the workshops, the HCAs were also encouraged to think about their core values and agree new ways of working, together and in the wider team. Critical questions that arose from the session were captured for broader dissemination with the team and would form the basis of action plans. These included:

- How do we find out what matters most to the patient that day?
- How can we ensure there is a plan for staff before they begin giving care?
- How can we improve HCA- RN communication at the beginning of the day?
- How can we ensure the patient care plan is always kept at the bedside?
- How do we make sure that the person recording care is the person that has delivered it?
- How can we support staff to manage all the changes?
- How can we help/support people to manage stress?
- How can we get help from other departments to help on wards when it is really busy e.g. mealtimes
- How can we continue and strive to improve communication within the team- no “them and us”?
- How can we improve first patient handover? Can we call the safety brief something else?

There was commitment that the HCAs remaining involved in all aspects of person-centred work. These new approaches to facilitation of learning brought some challenges to both facilitator and participants. Some participant felt emotional when asked to examine themselves and their practice. The facilitator raised the importance of ‘holding the space’ for deep learning to occur, but also making time and space to reflect on her developing facilitation expertise.

### **Embodying contrasts**

For persons to flourish, feeling respected and showing respect are key ingredients. Being respected as a person enables growth whilst simultaneously creating the conditions for the

demonstration of respect for others. As well as identifying changes to practice and team-working, members of the core group identified specific learning arising from the programme of work. A template with key questions was distributed to all group members for them to complete. Key learning from staff mainly focused on recognising that person-centredness is not just person-centred care, but is a way of being when engaging with all others. Following the programme one person identified:

*I understood better what person centredness within the staff looked like and what it should feel like.*

Another reflected:

*I have learned how important it is to step out of the comfort zone in a focussed way to really see what we are doing and how it might be different. I have also learned how important it is to use relevant examples to demonstrate how PCC has embedded in our hospice rather than trying to explain what it is!*

Participating in the programme also led to the use of more person-centred language:

*I use the words 'person centred' a lot more now! It has made me think more about other people's roles and how what I do impacts on them, and how their role impacts on my role.*

Others identified that they were surprised how much the focus was on the team and that that is where the biggest changes seemed to have been made:

*I don't think it has changed my practice but I have seen very positive changes in a number of clinical and non-clinical colleagues in terms of engagement with, and feeling more part of, the hospice team*

Perceived changes are around language and the sense of team:

*I think most staff are aware of person centredness now, even if they don't really realise it! People have definitely been talking about person centred approaches to things when maybe they might not have before. I think staff are realising as well that it applies to them too, not just the patients. There is more understanding of different roles now as well, although this could be improved I reckon.*

*The sense of being part of a team and being valued as part of that team has significantly changed for the better for some staff. There is a willingness to consider and understand other's roles and an awareness that this is an important part of working in the hospice. Notable outcomes have been the new induction model and a huge amount of teambuilding energy coming from the admin team!*

## **Harmony**

There is no beginning and no end to flourishing (McCormack and Titchen 2014). Acknowledging that there is no beginning and no end brings dynamism to the practice, a dynamism that is responding to the context and the persons who shape that context and that creates a dance between the specifics of the practice and the vision for transformation. However, this is also reflected in indicators of success collected from multiple sources i.e. the Health Improvement Scotland (HIS) report, a review of complaints, a report of a pilot project implementing a Practice Development Registered Nurse role and staff survey.

### *Health Improvement Scotland Inspection*

In May 2017, there was an unannounced inspection report published by HIS. Although in 2016, there were 9 recommendations from the inspection including improving and evaluating staff well-being and two around patient and family involvement in care planning in the 2017 report, HIS scored The Hospice as excellent in four of the five categories. The fifth scored very good (Figure 1). The report is available at

[http://www.healthcareimprovementscotland.org/our\\_work/inspecting\\_and\\_regulating\\_care/independent\\_healthcare/hospices/marie\\_curie\\_hospice\\_edinburgh.aspx](http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/hospices/marie_curie_hospice_edinburgh.aspx)

#### **Quality Theme 0 – Quality of information: 6 – Excellent**

Quality Statement 0.2 – service information: 6 – Excellent

Quality Statement 0.3 – consent to care and treatment: 6 – Excellent

#### **Quality Theme 1 – Quality of care and support: 5 – Very good**

Quality Statement 1.1 – participation: 6 – Excellent

Quality Statement 1.4 – medicines management: 5 – Very good

**Quality Theme 2 – Quality of environment: 6 – Excellent**

Quality Statement 2.2 – layout and facilities: 6 – Excellent

Quality Statement 2.4 – infection prevention and control: 6 – Excellent

**Quality Theme 3 – Quality of staffing: 6 – Excellent**

Quality Statement 3.2 – recruitment and induction: 6 – Excellent

Quality Statement 3.4 – ethos of respect: 6 – Excellent

**Quality Theme 4 – Quality of management and leadership: 6 – Excellent**

Quality Statement 4.2 – workforce involvement: 6 – Excellent

Quality Statement 4.4 – quality assurance: 6 – Excellent

**Figure 1: Summary of HIS Report**

The report identified the positive culture of the hospice, noting staff worked well as a team, they felt valued and respected. The quality of the environment was also highlighted as excellent, noting there was a welcoming atmosphere with bright posters, information boards and staff photographs. There was also evidence of a culture where feedback is sought and valued. Inspectors invited comment from patients and families,

*‘The staff have been wonderful. I am included in discussions about my wife’s care. The staff are really interested in the whole family and our experiences which helps us to cope better.’*

**Complaints review**

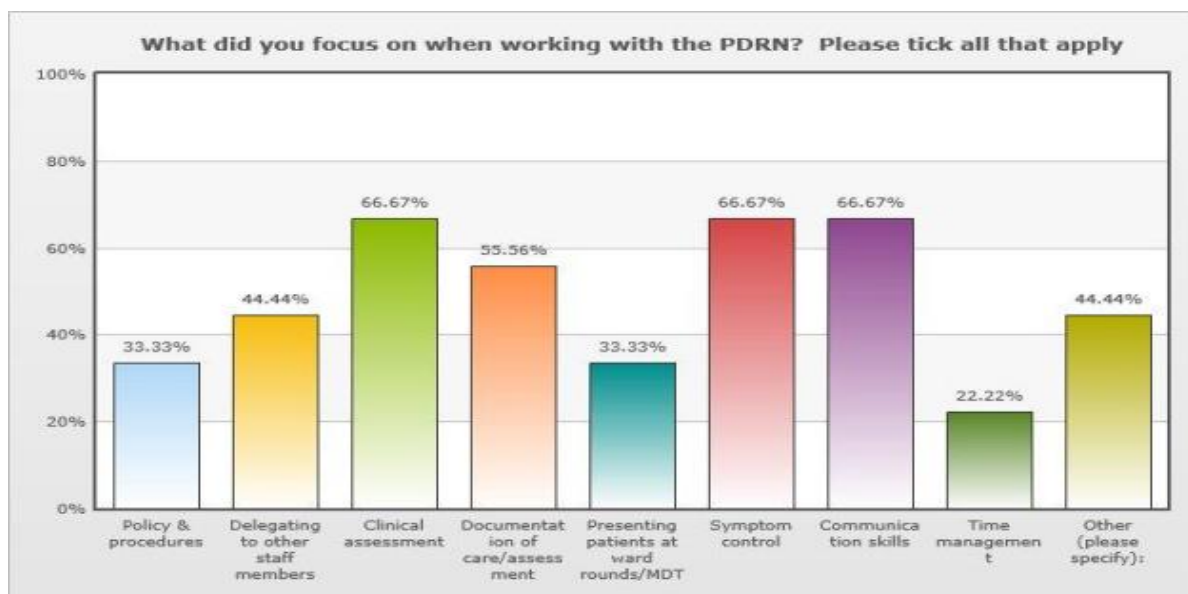
A review of complaints within the hospice revealed a drop in the number of complaints from 30 in 2016 to 18 in 2017. The approach to handling complaints includes evaluation of the process and reflection and learning, reflecting openness to change. Some examples include:

- Reflection by individuals involved and individual action plans as appropriate
- Improvements to hospice procedures following communication and environmental issues. Examples of this include:
  - Development work carried out with staff and in partnership with the local prison
  - Change in security personnel covering the hospice overnight

- Review and improvements to pathways for communication with patients in the community teams.
- Use of reflective sessions, regular meetings and staff-specific emails to highlight and draw out learning from complaints.
- One complaint led to a disciplinary hearing but no further action was taken.

#### *Practice Development Registered Nurse (PDRN) Pilot*

In response to high staff turnover and some instability in the Hospice Inpatient Unit, (IPU) during 2015 and early 2016, a 6-month pilot was proposed to create a supernumerary PDRN post. This was an experienced nurse who would provide mentorship and support for newer and less experienced nurses with the aim of improving retention rates and staff wellbeing. The focus of support is captured in survey data gathered from RNs in the inpatient unit. Figure 2. There was a 60% response rate.



**Figure 2: Staff Wellbeing data results**

At the end of the pilot, PDRNs were invited to be interviewed. Rather than trying to direct with pre-set goals, the PDRNs worked with the RN's individually to identify gaps in knowledge and areas for development. One PDRN commented:



894 *"It was about enabling people rather than about them feeling judged"* Feedback on the role  
895 was encouraging'

896 Other positive feedback was gained from the multi-disciplinary team.

897 *"As a ward doctor I would like to emphasise how helpful this role was in the management of*  
898 *patients' complex symptoms. It was noticeable when the PDRNs were around and the*  
899 *improved assessment and decision making from the ward staff nurses both at the time the*  
900 *PDRN was on the ward and afterwards"*

901 This was confirmed by a comment in the RN survey

902 *"Being able to more confidently manage symptoms. Rather than questioning myself as*  
903 *much, I'm more comfortable with the rationale.*

904

905 Retention rates were scrutinized during and following the pilot. Numbers of RNs leaving the  
906 Hospice decreased by 40% from 10 leaving April 2015 – March 2016 to 6 leavers from March  
907 2016 to March 2017. There is currently a period of stability within the IPU. None of the  
908 recently recruited RNs have left during the time that this additional support was in place.

909 *Staff Survey*

910

911 In July 2017, all staff were invited to complete a survey to get insight into whether they  
912 believed the culture was changing. 24% staff (N=28) responded which may reflect levels of  
913 enthusiasm for the work. 60% of responded that they felt the culture had become more  
914 person-centred, whilst staff remain focussed on 'patient-centred' caring. There is reportedly  
915 an increased willingness to,

916 *discuss and give feedback in an open and honest environment without fear of being judged*  
917 *or ignored.*

918

919 A Registered Nurse commented,

920 *Among the staff at the hospice, I think there is more awareness of, and attention paid to,*  
921 *each other – names, experiences, life stories and aspirations. Time is taken to listen, talk and*  
922 *empathise. The white boards provide an opportunity to share information and learn more*  
923 *about each other.*

924

925 A staff member in psychology noted

926 *It's not a huge change but I do like the notice boards. They remind me that everyone in the*  
927 *building has their own life outside it too.*

928

929 The newsletter appears to play an important role in this, one of the Clinical Nurse Specialists  
930 reporting that together with activities board and staff events,

931 *[it has] helped me to get to know other staff better. Newsletters help us to feel we are all in*  
932 *this together.*

933

934 A newer member of the team reported,

935 *From my time of working here, I can see the person centre culture being at the forefront of*  
936 *MC. One example is when we helped organise for a patient's relatives' birthday and it was*  
937 *held in Day Therapies. The family were very appreciative and fond memories of the hospice*  
938 *as well.*

939

940 A member of staff working in the kitchen commented,

941 *Staff seem to be a bit more aware of their job roles and what impact they might have*  
942 *on them. Staff seem more friendly, especially some ward staff.*

943

944 The data revealed some examples of 'task-focussed' rather than 'person-centred'  
945 approaches to care continuing in the wards.

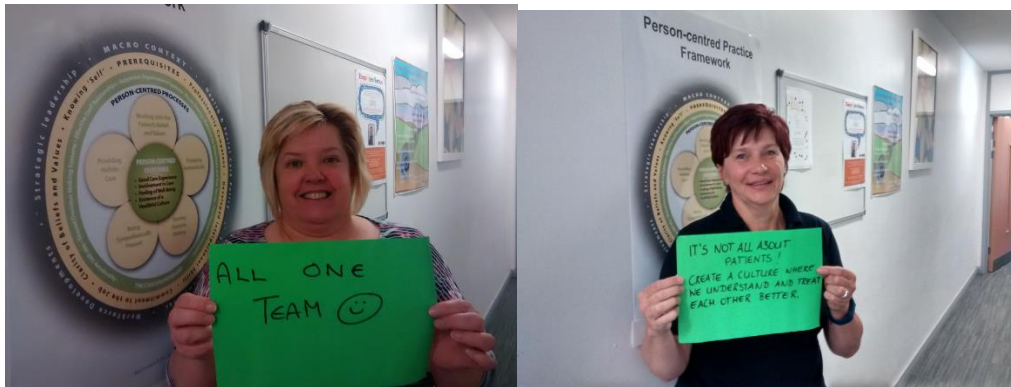
946

947 *Still a lot of staff feeling every patient needs to be washed in the mornings when it's a*  
948 *24-hour service. Can be done when time is right for patient. Also, breakfast tray going*  
949 *out early in the morning. Feel trays should be put out when receiving breakfast, not at*  
950 *6am in the morning.*

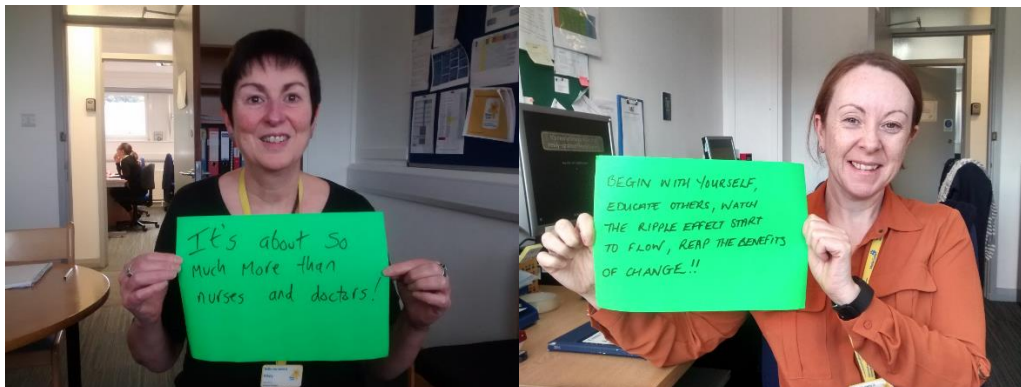
951

952 There were examples in the data of cross-team working e.g. fundraising; increased  
953 participation in hospice meetings and; improved inspection results. In the survey,  
954 respondents were asked if they had noticed any changes within themselves. Respondents

955 revealed they were more aware of other people's needs, but also their aspirations. Respecting  
956 others was also revealed where the pharmacist noted,  
957 *I always say 'hello, my name is....' I always hoped I was person-centred and tried my best for*  
958 *all patients and treat them as individuals*  
959  
960 and another member of the team,  
961 [I have] *a greater general awareness of other staff and their experiences/what motivates*  
962 *them/challenges them. Broader perspective in general*  
963  
964 There were examples of people having the intent of shared decision-making, not deciding  
965 '*best treatment for them*' but asking what they want. One of the administration team  
966 identified,  
967  
968 *I try to think more out of the box when it comes to solutions. I try to be more mindful of how*  
969 *I might impact on others*  
970  
971 One of the registered nurses captured the change in thinking that is occurring,  
972 *The whole of my nursing career since 1974 has been based on Virginia Henderson's*  
973 *definition of nursing. This holistic, individualised approach to nursing care is inherent in me,*  
974 *and has always extended to families. What has changed for me is taking a similar approach*  
975 *to the staff I work with and encounter – especially new members of staff, or those I engage*  
976 *with for a short time only. It is important to take that time to listen and talk and not make*  
977 *impulsive, unfounded judgement.*  
978  
979 Individuals in the project team captured changes in their perspectives and key learning. This  
980 is captured in these photographs:



981



982



983

984 There is commitment to sustaining ways of working and ongoing development of the PD  
 985 group and to continue to celebrate successes. When asked what they would like to see  
 986 happen next, Brigid and Juliet responded:

987 *I'd like to see more things being done to bring staff together (if they want to*  
 988 *obviously!) and more staff taking a lead in this, not just the same people. I'd like to*  
 989 *see development of respect, recognition and understanding of roles, especially*  
 990 *towards non-clinical staff. (Brigid)*

991 *I would like to see a specific piece of work with the HCAs that involves all of them. I*  
 992 *would like the group to have a clear idea by December of how we maintain the*  
 993 *momentum and how we establish the benefit for patient and families. (Juliet)*

This is occurring through sharing with other hospices and community services within Marie Curie, as well as presenting to the Executive Team and stencilling the shared vision in the reception area. The summer fete in July 2017 was used as an opportunity to celebrate success and a celebration event is planned in April 2018.

Finally, in the beginning it was difficult to engage non-clinical services, although this changed over time. As the programme continues, new members are being recruited, including for example, a member of the domestic staff. In addition, new HCAs and RNs are being invited into the group, with the overall effect of creating a sustainable group committing to the ongoing facilitation and leadership of the work longer-term.

#### *Next Steps*

Harmony is also reflected in the embeddedness of the person-centred culture. The core group have ongoing plans to continue to develop practice. Currently, they are:

- Using a range of opportunities to have dialogue around person-centredness including.
  - Auditing how many people read the hospice newsletter.
  - Start looking more at 'tasked' routines – joint HCA/RN groups.
  - Facilitate opportunities for discussion and reflection with 'in-patient unit' staff relating to concerns about staffing changes/cuts
- PCC group continues to meet to:
  - Turn 'time line' into 'poster' based on PCC model – one for the hospice, two others to be used in wider dissemination. Also to be incorporated into hospice presentations
  - Agree ongoing steps and plan for wider publicity/presentations.
  - Arrange social events.
  - Plan public presentation – at the hospice fete.
  - Consider next stage of process which might include:
    - Further multi-disciplinary sessions
    - Participation in the PCC group
- Consider use of new presentation 'app'.

## DISCUSSION

The person-centred development at The Marie Curie Hospice Edinburgh illustrates how a systematic, collaborative and inclusive approach to culture change can have wide-ranging effects on the lived experience. Using human flourishing as a framework has helped us to get 'inside and underneath' the processes and outcomes and demonstrate a holistic approach to the development of person-centred cultures that keeps the person at the centre whilst dealing with improving areas of engagement and quality. This is consistent with the methodology of transformational practice development (ref). In this methodology, the purpose is to transform cultures towards those that are places where all persons flourish. Transformational practice development is person-centred in its philosophy and uses methods that respect the diverse nature of persons, their ways of being and processes of engagement. It is not a linear process, but instead aims to 'be with' participants in ways that respect each unique learning journey. Transformation is sustained through active learning (ref). However, whilst this philosophy and methodology has laudable holistic aims, in reality a mechanistic and technical approach to creating change can override the core intent of transformation through learning. Indeed, this contradiction was evident at the beginning of this project where the group had a desire to see tangible changes in practice at the expense of transformation of ways of being through learning. As facilitators this was challenging and 'holding the space' was important to enable perspective transformation and ongoing commitment to the agreed ways of working and the methodological approach. The framework of human flourishing provided a useful means of doing this, so that all activities could be understood through the concept of flourishing and how this happens and is sustained. For example, whilst many practice development programmes can have the intent of culture change and transformation, too quickly the focus can shift to completing individual (mini) projects and evaluating their impact – thus losing the bigger picture of culture transformation. Indeed a focus on mini-projects is advocated by practice developers as tangible evidence of the translation of new learning into practice (Dewing, McCormack & Titchen, 2016). In this programme, whilst mini projects were developed (see table 2), these were understood in the context of 'embracing the known and yet to be known' and so were platforms for reflection, analysis and increasing engagement rather than as 'ends' in themselves. These mini-projects provided a wide range of opportunities to demonstrate a

holistic approach to person-centredness and a shift from providing person-centred care to the development of a person-centred culture that can sustain such caring practices (some of our references here).

The relationship between person-centred care and person-centred cultures was particularly interesting in this programme. At the time when this work commenced, the results of a national patient survey by Marie Curie Care suggested high levels of patient-satisfaction with care provided in the Edinburgh Hospice. This was in part reinforced by the patient story data in this project. More significantly however, our data revealed the lack of person-centredness experienced/felt by staff in the hospice and related services. This was a challenge at the beginning of the programme when some participants couldn't see the point of it, given the high levels of patient-satisfaction. McCormack and McCance (2010 and 2017) have consistently argued the need for a person-centred culture to sustain person-centred care and this argument was evident in the culture of this care setting. Whilst the organisation's data demonstrated high levels of patient satisfaction, this was not the case for staff satisfaction. Evidence of this existed in the narrative data of this programme and this data reflected informal communications in the setting up of the programme and staff satisfaction and retention data maintained by the hospice itself. It was this lack of staff satisfaction that drove the need for this programme and the desire to address the culture of the care setting. As a result, programme evaluations demonstrated little effect on person-centred care but significant improvement in staff satisfaction and the overall care culture of the service, as illustrated through the staff survey and the Health Improvement Scotland's (HIS) quality monitoring report.

The existence of person-centred care in the absence of a person-centred culture is an interesting conundrum! Buetow (2016) has argued that this raises moral questions that organisations need to address, i.e. can staff be sacrificed for the outcome of person-centred care? This is a question that the hospice leadership and management team were not comfortable with being a reality in their service, i.e. the continuous loss of staff from the organisation while patients and families remain satisfied with their care. This dilemma in organisations however is not always addressed explicitly in the way that this team chose to, resulting in organisations either espousing a person-centred philosophy, whilst in reality focusing on patient-centredness (ref). It was a revelation to most of the participants in this

programme that person-centredness was about more than patients and that they had a right to consider these values for themselves. Other studies, particularly those operationalising the values of 'Magnet Hospitals' (refs), Planetree (ref), Culture Change (refs) and <IHI joy at work> (Ref) do recognise the need for staff to be treated with respect and dignity as a means of improving the quality of care experience for patients. However from a moral perspective, this approach privileges one person over the other and uses one as a means to the other's end, rather than an end in themselves (ref). The results of this programme demonstrate an equalising of perspectives and respect for the personhood of all persons engaging with the service, irrespective of role and creating a person-centred culture that can be sustained over time. McCormack and Titchen (2014) suggest that this kind of culture represents the eight condition for human flourishing – loving kindness:

*“Loving kindness lies at the heart of flourishing; loving kindness towards oneself and others in the contexts and situations we find ourselves in our work. Speaking loving kindness is like feeling breeze on our faces, hearing the rustle and brushing of grasses and leaves as the wind gusts and lulls. It is something that is sensed more than actually spoken although it can be heard in the tone of voice, in the softness of the eyes and in compassionate acts. Loving kindness warms our hearts as the sun warms the earth and all living things ...”.*

## CONCLUSIONS

In this paper we have provided a detailed account of the processes and outcomes of a programme specifically designed to develop a person-centred culture in a palliative and end-of-life care service. The programme utilised a transformational practice development approach for the development of a person-centred culture and a framework for human flourishing as a means of analysing processes and outcomes. The programme demonstrated the importance of person-centred cultures for sustainable person-centred care. The creation of such cultures is imperative if sustainable person-centred care is to be made a reality. Human flourishing is a desirable moral goal in organisations that recognises the need for the personhood of all persons to be respected . If we are to move beyond the rhetoric of person-centredness and truly embrace its values, then the continuous articulation of 'patient-centredness disguised as person-centredness' needs to end. We believe that the



1117 transformational engagement processes used in this programme offer a means of achieving  
1118 this goal.

1119

1120 **REFERENCES**

1121 **To be added**